State Employees' Group Insurance Program

Employee Group Insurance Enrollment/Change Form

(Annuitants and Survivors should contact their retirement system for the appropriate enrollment/change forms)

New and existing employees should use this form to elect coverage for the first time or change coverage elections during the plan year. Existing employees wishing to make a change should contact their Group Insurance Representative (GIR) to determine if they have a qualifying event and if so, the date the change would be effective and any documentation requirements. All employees should periodically update their Beneficiary Forms. All part-time employees must also complete the Part-time Election form.

New Hire: Complete this enrollment form and return it to your GIR within 10 days of your hire date. Coverage will be effective retroactive to your hire date. If you elect dependent health coverage, they must be enrolled in the same plan as you. **FAILURE TO RETURN THIS FORM** to your Benefits Office within 10 days of your hire date will result in automatic enrollment in the Quality Care Health Plan and Quality Care Dental Plan with no dependent coverage and Basic Life coverage only.

Change Current Election and/or Add Dependent(s): If you wish to change any of your current elections, only complete the Employee Information section and the information you wish to change. If you are enrolling dependent(s) during the plan year, also complete the Dependent Information section on page 2. If your dependent resides at a different address than you, complete the Address Change form. If you are adding/changing more than four dependents, please use additional copies of page 2.

Employee Information ☐ **Initial Enrollment** **Email Address:** _____

☐ **Change Election - Reason** _____ **Date of Event** _____

Last Name	First Name (legal)	Middle Name	Social Security Number (required)	Residential County

Residential Street Address	City	State	Zip	Employment Status
				☐ Full-Time ☐ Part-Time (must also complete Part-time Election form)

Primary Phone Number	Alternate Phone Number	Is your Spouse/Civil Union Partner a State Employee/Annuitant?	Gender	Are you Disabled?
		☐ No ☐ Yes, agency _____	☐ Male ☐ Female	☐ Yes ☐ No

Date of Birth	Marital Status	Medicare Status (If you have Medicare, you must provide a copy of the Medicare card)
	☐ Single ☐ Married	☐ Non-Medicare ☐ Ineligible Age 65+ ☐ Age 65+ ☐ Disability ☐ End-Stage Renal Disease

Health Insurance Coverage Election (includes vision)

☐ **Please (1) enroll me in the health coverage or (2) change my health plan election.** Employees must choose their health plan election below.

Check the appropriate box below for your health plan election. Members choosing an HMO must complete the 6 - 10 character Provider Identifier #. The Provider Identifier # can be found by contacting the HMO plan administrator by phone or the plan's website.

Health Plan Name	HMO Health Plan Name	Provider Identifier #	HMO Health Plan Name	Provider Identifier
☐ Quality Care Health Plan	☐ Health Alliance Illinois (BS)	_____	☐ BlueAdvantage HMO (CI)	_____
☐ HealthLink OAP (CF)	☐ Health Alliance HMO (AH)	_____	☐ HMO Illinois (BY)	_____
☐ PersonalCare OAP (CH)	☐ PersonalCare HMO (AS)	_____		

Coordination of Benefits

☐ Yes, either I or my covered dependents have other group health coverage. If 'Yes,' you must provide a copy of the other group health ID card.

☐ No, I do not have other group health coverage.

☐ **I do not want health, prescription, dental and vision coverage.** Full-time employees must provide proof of other group health coverage provided by an entity other than CMS in order to OPT OUT of the coverage (employees must complete an Opt Out form). Part-time employees do not need to have other coverage in order to waive.

Dental Insurance Coverage Election (If you have another group dental plan you must provide a copy of the front and back of the dental ID card to your GIR for coordination of dental benefits)

New Employees or **Full-time Employees Opting Back Into Group Insurance**	☐ Yes, I want the dental coverage	☐ No, I do not want the dental coverage. I understand if I choose not to enroll in dental, I cannot enroll until the next annual Benefit Choice Period.

Benefits Website: www.benefitschoice.il.gov

Complete page 2 of this form to add or change life and/or dependent coverage

ONLY COMPLETE THE SECTIONS YOU WISH TO ADD OR CHANGE

Employee Name:_____

Life Insurance Coverage Election

BASIC and MEMBER OPTIONAL LIFE †				AD&D (Accidental Death & Dismemberment)	Dependent Life Coverage ($10,000 each) †
☐ Basic Life (equal to annual salary) – Basic Life is free and automatic for all employees except those on certain LOA's, in which case the employee must elect the coverage and pay 100% of cost ☐ Waive Basic and Member Optional Life (only applies to employees on certain LOAs) ☐ Basic and Member Optional Life (select optional coverage increment below)				☐ NO AD&D ☐ BASIC only (Equal to Salary) ☐ COMBINED (Equal to Basic Life + Optional Life*) * AD&D Combined will not exceed 4 times optional	☐ NONE ☐ CHILD * ☐ SPOUSE or CIVIL UNION PARTNER * All dependent children age 25 and under are eligible for life coverage, except individuals enrolled in the 'Other' category. Note: If electing Child or Spouse/Civil Union Partner Life you must complete the 'Dependent Information' section.
○ 1 x Salary	○ 3 x Salary	○ 5 x Salary	○ 7 x Salary		
○ 2 x Salary	○ 4 x Salary	○ 6 x Salary	○ 8 x Salary		

† New Hires: Only Member Optional Life requests in amounts of 5 – 8 times require completion of a Statement of Health application.
After Initial Enrollment: Member Optional Life requests in any increment (1 – 8 times) require completion of a Statement of Health application.
After Initial Enrollment: Spouse/Civil Union Partner and Child Life requests for dependents that are not newly added due to marriage, civil union or birth require completion of a Statement of Health.

Dependent Information – All dependent enrollments require additional documentation to be submitted verifying eligibility (see your GIR for documentation requirements).

Add (A); Drop (D) or Change (C)		Name (legal) (First Middle Last)	SSN (Required)	Date of Birth [1]	Relationship Type (see list below)	Provider Identifier # (only required for HMO plan coverage)	Sex (M/F)	Other Coverage[2] (Y/N)
HEALTH	LIFE							

[1] If you have dependents with the same birth date including year (e.g. twins), in addition to the birth date you must put a #1 in the **Date of Birth (DOB) field** on the line of the child who was born first; put a #2 in the DOB field for the child who was born second, etc.

[2] If your dependent has other group health or dental coverage, including Medicare, you must provide a copy of the front and back of the card to your GIR.

Relationship Types for Spouse/Civil Union Partner and children age 25 and under:
• Spouse (01) • Civil Union Partner (Non-IRS – 1C; IRS – 1D) • Natural Child (02) • Adopted Child (03) • Stepchild (04) • Civil Union Child (Non-IRS – 4A; IRS – 4B)
• Legal Guardianship (06) • Adjudicated Child (07)

Relationship Types for all other children (age 19 or older). A CMS-138 form must accompany enrollment requests for these dependents (available on the Benefits website).
• Disabled (09) • Other (transplant recipient – 10) • Adult Veteran Child (Non-IRS – 13) • Adult Veteran Child (IRS – 14/15)

I authorize premiums as established annually to be deducted from my pay for those plans I have selected. I understand that if my paycheck is insufficient or if I am not on payroll, I will be direct billed. The information contained in this form is complete and true. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected. I understand it is my responsibility to review my paycheck and verify the amounts of the insurance deductions are accurate. I understand that if my deductions are not correct I must immediately contact my GIR. Falsification of the information contained on this form may result in discipline up to and including discharge. Additionally, the Department of Central Management Services (CMS) may impose a financial penalty, including, but not limited to, repayment of all premiums the Program made on behalf of the enrolled individual, as well as expenses incurred by the Program.

Employee Signature: _____ Date: _____

Who is my GIR? Go to 'Contact Information' on the Benefits Website.

GIR/P USE ONLY: Payroll Deduct Codes: Health: _____ Dental: _____ Life: _____ Non-IRS Dependent: Health: _____ Dental: _____

Effective Date: _____ Type/Subtype: _____ PT%: _____ Salary: _____ Deduct Frequency (M/S): _____

Distribution Code: _____ Payroll Agency: _____ Work County Code: _____ Org Proc Code: _____

Change in Status Reason Code: _____ Dependent Term Code: _____ Date of Hire: _____ (initial enrollments only)

GIR/GIP SIGNATURE: _____ DATE: _____